CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-0391		
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155505	B. WING		09/01/2011		
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268 ID PROVIDER'S PLAN OF CORRECTION (X5)				
PREFIX TAG		(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE		
K0000							
	State Licensure of the Indiana State accordance with Survey Date: 09 Facility Number Provider Number AIM Number: 1 Surveyor: Mark Specialist At this Life Safe Run Health Cent compliance with Participation in 1 CFR Subpart 48 Fire and the 200 Fire Protection A Life Safety Code Existing Health 410 IAC 16.2. This one story fabe of Type V (11 fully sprinklered alarm system with	: 01156 r: 155505 00453350 Caraher, Life Safety Code ty Code survey, Robin ter was found not in Requirements for Medicare/Medicaid, 42 3.70(a), Life Safety from 0 Edition of the National Association (NFPA) 101, e (LSC), Chapter 19, Care Occupancies and accility was determined to 1) construction and was . The facility has a fire th smoke detection in the	K0000	The following is the Plan of Correction for Robin Run Healthcare Center regarding Statement of Deficiencies of 9/2/11. This Plan of Correct not to be construed as an admission of or agreement the finings and conclusions Statement of Deficiencies, or related sanction or fine. Rat is submitted as confirmation our ongoing efforts to comp statutory and regulatory requirements. In this document we have outlined specific action response to identified iss. We have not provided a det response to each allegation finding, nor have we identificating factors. We remain committed to the delivery of quality health care services will continue to make changand improvement to satisfy objective.	g the ated tion is with in the or any other, it in of ly with ment, etions ues. called a or ed ain et and ges		
		nt rooms and areas open The facility has a capacity					

of 84 and had a census of 67 at the time of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B3HQ21

Facility ID:

001156

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	A. BUILD B. WING		01	(X3) DATE S COMPL 09/01/2	ETED	
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE	
K0076 SS=E	The facility was with the aforeme requirements as a following: Medical gas storagare protected in ac Standards for Heat (a) Oxygen storag 3,000 cu.ft. are enseparation. (b) Locations for sthan 3,000 cu.ft. a NFPA 99 4.3.1.1.2 Based on observations cubic feet was sed distance of at leat combustible matt 8-3.1.11.2(c) required such as oxygen storage locations cubic feet if the reprotected by an asystem. This defaffect any resident	ge and administration areas accordance with NFPA 99, lth Care Facilities. e locations of greater than closed by a one-hour upply systems of greater re vented to the outside. 19.3.2.4 ation and interview, the ensure 1 of 2 oxygen of greater than 3000 parated a minimum st five feet from	K00	76	I. All residents have the pote to be affected by the deficient practice. The deficient practice was immediately corrected be relocating the four shelf storal rack containing combustible supplis, blankets, towels and clothing out of the oxygen stowarea. II. All residents residing the facility have the potential affected by the deficient practice that the facility will conduct a dain facility round to ensure that the oxygen storage locations are separated a distance of five (feet from combustible materials. III. In order to previous to be affected by the deficient practice.	ttice y age linen orage g at to be stice. ly he	09/01/2011	

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Event ID:

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/01/2011				
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	Findings include Based on observe Plant Operations facility from 11:: 09/01/11, the oxystransfilling room contained one lid which was 75% the liquid oxygen four shelf storage combustible line towels and clother at the time of observed Plant Operations combustible support three feet of the storage combustible support of the stora	in the Clare Bridge Hall. ation with the Director of during a tour of the 55 a.m. to 2:00 p.m. on ygen storage and in the Clare Bridge Hall quid oxygen canister full. Within three feet of a storage canister was a erack which contained an supplies, blankets, ing. Based on interview servation, the Director of acknowledged plies were stored within liquid oxygen canister in oxygen storage and		the deficient practice from recurring, the facility will ins all maintenance staff on the storage required distance to maintain resident safety. IV facility will monitor the correactions by the Director of Engineering and/or designe performing rounds daily for month and weekly for one month. The results will be reviewed at the facility's Qu Assurance Committee and revisions will be made if neand as directed by the committee. The Director of Engineering Services will enongoing monitoring after the aforementioned monitoring period.V. The deficient practice was completed on 9/1/11.	ervice The ective e one ality eded nsure			

001156

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
155505		B. WING			09/01/2	011	
NAME OF D	DOMBER OF CHIRD IED		F		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				6370 RC	DBIN RUN W		
	UN HEALTH CENT	ER			APOLIS, IN46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	Transferring of oxy	· · · · · · · · · · · · · · · · · · ·	•	IAG	BEITELENETY		DATE
K0143 SS=E	Transferring or oxy	ygen is.					
30-L	wherein patients a treated by a separ	(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of					
	1-hour fire-resistiv	e construction;					
	(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and						
(c) in an area posted with stransferring is occurring, are the immediate area is not paccordance with NFPA 99 Compressed Gas Associat 1. Based on observation the facility failed to ensure oxygen storage areas were signage indicating oxygen		a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 ervation and interview, I to ensure 2 of 2 liquid creas were provided with ag oxygen transferring is	K	1143	I. All residents have the pote to be affected by the deficien practice. The deficient practic was immediately corrected by applying door signage indicates the properties.	t ce y ting	09/01/2011
	affect any resider vicinity of the ox transfilling room	deficient practice could nts, staff or visitor in the tygen storage and near Room 30 and in the and transfilling room in Hall.			that oxygen is transfering. The deficient practice was completed by disconnecting the fan from the on/off switch to allow for proper ventilation in the oxygen transfilling room. II. All residents residing at the facility have the potential to be affected by the		
	Findings include:				deficient practice. The facility will conduct a daily facility round to ensure that the oxygen		
	Based on observa	ations with the Director			transferring signs are afixed		
	of Plant Operation	ons during a tour of the			the oxygen room doors and t		
		55 a.m. to 2:00 p.m. on			the oxygen transfilling room on Clare Bridge is properly ventilated.III. In order to prevent		
	09/01/11, the oxy	ygen storage and					
	transfilling room	near Room 30 and the			the deficient practice from		
	•	nd transfilling room in			recurring, the facility will ensu compliance of the permanent		
		Hall each were not			signage to the doors where li		
	provided with a s				oxygen is transferring and the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
155505		B. WIN			09/01/2	U11 	
NAME OF	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN F	RUN HEALTH CENT	IER		INDIAN	APOLIS, IN46268		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΕ	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	_	TAG			DATE
	1	xygen was occurring.			facility will ensure proper ventilation to the oxygen		
	1	ew at the time of			transfilling room.IV. The facil		
	•	Director of Plant			will monitor the corrective ac		
	_	d the transferring of			by the Director of Engineerin	-	
		eur in each oxygen			and/or desginee completing		
	1	and acknowledged each			weekly observation for one nether a monthly observation f		
	oxygen storage a	and transfilling room was			then a monthly observation three months. The results wireviewed at the facility's Qua		
	not provided wit	th a sign indicating					
	transferring of oxygen was occurring in				Assurance Committee and		
	each oxygen stor	each oxygen storage and transfilling			revisions will be made if nee	ded	
	room.				and as directed by the committee.V. The deficient		
					practice was completed on 9/1/11.		
	3.1-19(b)						
	2. Based on obs	ervation and interview,					
	the facility failed	d to ensure 1 of 2 liquid					
	oxygen storage a	and transfilling rooms was					
	provided with co	ontinuous mechanical					
	ventilation. This	s deficient practice could					
	affect any reside	ents, staff or visitor in the					
	1	xygen storage and					
	1	in the Clare Bridge Hall.					
	[ing room in the chare Bridge rian.					
	Findings include):					
	I manigo merade.						
	Based on observ	ration with the Director of					
		during a tour of the					
	1 -						
	facility from 11:55 a.m. to 2:00 p.m. on 09/01/11, the oxygen storage and						
	1						
	transfilling room in the Clare Bridge Hall which is used to store one liquid oxygen						
	1						
		provided with continuous					
	1	ilation. A mechanical					
	vent was observe	ed in operation but it was					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPL	ETED
155505		B. WING			09/01/2	011	
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144 SS=F	Based on intervitor observation, the considered part of storage and transprovided with conventilation. 3.1-19(b) Generators are insexercised under low month in accordar 3.4.4.1. Based on observation facility failed to a generators was emanual stop. NF Facilities, 3-4.1.1 installed as alternated the requirement of the requirement of the systems. NFPA Level II installation manual stop statistically for the Installation of	Director of Plant owledged the oxygen offilling room was not ontinuous mechanical spected weekly and oad for 30 minutes per nce with NFPA 99. ation and interview, the ensure 1 of 2 emergency quipped with a remote FPA 99, Health Care 1.4 requires generator sets nate power sources shall ments of NFPA 110, ergency Standby Power 110, 3-5.5.6 requires ions shall have a remote on of a type similar to a on located outside of the orime mover is located. tates NFPA 37, Standard on and Use of Stationary ines and Gas Turbines, ory requirements for rators and shall be of the requirements of this	K0	1144	I. All residents have the pote to be affected by the deficient practice. The deficient practice was completed on 9/7/11 by vendor contracted to install a emergency stop switch on th generator.II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility corrected the deficient practice a vendor contracted install and emergency stop switch on the generator.III. In order to prevent the deficient practice from recurring, the emergency stop switch installed on the generand will be monitored to ensure proper functioning of the switch.IV. The facility will most the corrective actions by the Director of Engineering and/of desginee ensuring proper functioning weekly for one more contracted by the designee ensuring proper functioning weekly for one more contracted by the designee ensuring proper functioning weekly for one more contracted by the designee ensuring proper functioning weekly for one more contracted by the designee ensuring proper functioning weekly for one more contracted by the deficient practice.	nt ice a an e e e y ce by n e e vent ure uritor	09/07/2011
	standard. NFPA	37, 8-2.2(c) requires			then a monthly for three mon	iths.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION 01	(X3) DATE : COMPL			
155505		A. BUILI		01	09/01/2			
			B. WING		DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER				OBIN RUN W			
	RUN HEALTH CENT				APOLIS, IN46268			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
IAG				IAG	The results will be reviewed	at the	DATE	
	~	orsepower of more have utting down the engine at			facility's Quality Assurance			
	_	om a remote location.		Committee and revisions wil				
	~	actice could affect all			made if needed and as direc			
	residents, staff ar				by the committee. The Director of Engineering will ensure that			
	residents, stair at	id visitors.			monitoring will be continual a	after ring is		
	Findings include	:			the aforementioned monitoring complete.V. The deficient practice was completed on			
	Based on observa	ations with the Director			9/1/11.			
		ons during a tour of the						
	_	55 a.m. to 2:00 p.m. on						
	· -	ce of a remote shut off						
		ound for the 125 kW						
		gency generator which						
		th care portion of the						
		n interview at the time of						
	observation, the	Director of Plant						
	Operations stated	I the emergency generator						
	was installed prid	or to 2003 and						
	acknowledged th	ere is no remote						
	emergency shut of	off device for the						
	generator.							
	3.1-19(b)							